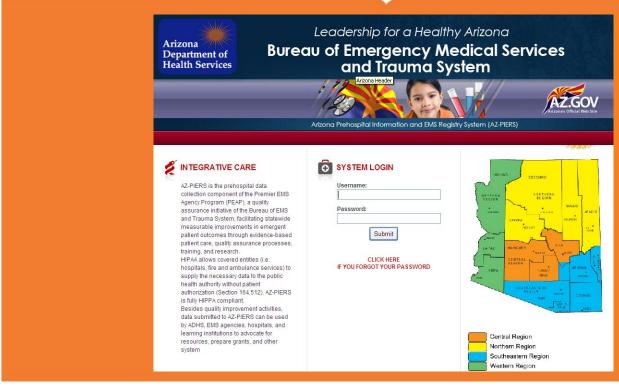
ARIZONA DEPARTMENT OF HEALTH SERVICES BUREAU OF EMERGENCY MEDICAL SERVICES AND TRAUMA SYSTEM

Premier EMS Agency Program (PEAP) Application October 2012







Bureau of Emergency Medical Services and Trauma System PEAP EMS Agency Application

Please provide all requested information using black or blue ink only. You may type or handwrite your responses

Section A. Agency Information									
1	Agency Name								
2	Business Address								
3	Phone Number								
4	E-Mail Address								
Section B. Agency Service									
1	Service Level	BLS ALS	вотн 🗌						
2	Number of EMS Runs/Yr	BLS: Transp. , Non-Tra	nnsp. , ALS: Transp.	, Non-Transp.					
Section C. Agency Administration									
1	Chief Administrator Name								
2	Phone Number								
3	E-Mail Address								
1	Admin. Medical Director Name(If Applicable)								
2	Phone Number								
3	E-Mail Address								
1	Base Hosp. Coordinator Name(If Applicable)								
2	Phone Number								
3	E-Mail Address								
1	QA Manager Name								
2	Phone Number								
3	E-Mail Address								
Section D. EMS Data Collection and Submission Agency									
1	Do you use electronic patie	nt care reports (ePCRs)?	YES (continue to 2,3)	NO (continue to 4)					
2	If YES, Who is your softwa	are vendor?							
3	If YES, What is the product name & version?								
4	If NO, When you will start using electronic patient care reports? N/A								
5	Will your agency send EMS Run Data to the Bureau of EMS & Trauma System? YES NO								

			S	ection :	E. EM	MS Q	Quali	ty A	ssut	ance	Э				
1	Does your EMS agency currently have a Quality Assurance Program?								YES 🗌	1	NO 🗌				
2	If Yes to E.1, please attach copies of your agency's QA process, and copies of approved policies that encompass 100% review of the four clinical areas: ST-elevation MI, Major Trauma, Stroke, and Out-of-Hospital Cardiac Arrest.														
3 Would you like assistance from the BEMSTS in establishing a QA process? YES \(\subseteq \) N										NO					
			Section	on F. Se	enior	Man	nagei	men	t Af	firm	atio	on			
I, the undersigned, as the Senior Manager for the named Agency listed in Section A.1 above herein this application agree to promote the quality assurance process within my agency. I will ensure that there exists a Quality Assurance Committee that meets at least quarterly and that I or my designee will attend. I further agree to ensure that written policies and procedures are produced, put in place, and followed that document the quality assurance process and include the four clinical areas: ST-elevation MI, Major Trauma, Stroke, and Out-of-Hospital Cardiac Arrest. If my agency utilizes an Administrative Medical Director responsible for the care provided by my agency, I will seek his/her participation in the quality assurance process. I will further ensure continued efforts toward achieving the four components necessary to be recognized as a Participant Agency in the BEMSTS Premier EMS Agency Program. I understand that the Premier EMS Agency Program is voluntary and non-punitive. I agree with the established mission of the program, which is to promote evidence-based treatments and integrated quality assurance process of the Arizona EMS and Trauma System to provide the best care for the citizens and visitors of Arizona.															
Senio	or Manager	Signature													
Printed Name:												Date:			
Thank you for applying to participating in the Premier EMS Agency Program. You will be contacted by a BEMSTS staff member via email within two weeks of the BEMSTS receiving your completed and signed application and signed Data User Affirmation Agreement to provide your ADHS-assigned Username and Password and the <i>Health Services Gateway Manual for PEAP Participants</i> .															
Description of QA Process (Required)															